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ABSTRACT

Preventing the spread of Acquired Immune Deficiency Syndrome (AIDS) among women is a national priority. In the United States, AIDS is the sixth leading cause of death among young adult women, and their rate of infection is four times higher than men. This article was developed to help stimulate interest in the power dynamics of relationships and how these might influence adolescent women's risk for acquiring the virus (HIV) that causes AIDS. It explores how high-risk adolescents view their personal power, the degree to which they see themselves as powerful in their ability to influence their steady partner and their relationship, and if these perceptions of power improve their ability to engage in safer sex behaviors. Preliminary analysis lends some support to previous theory and qualitative studies that suggested adolescent women's power and empowerment should be consideration for HIV prevention among high-risk adolescents. Also, an understanding of power dynamics in relationships is complex and must be contextualized in respect to gender and race. The pattern of results supports previous research that has found racial and gender differences in viewing power, relationships, and condom use. Preventing the spread of HIV and AIDS requires a clear understanding of the ways in which gender, culture, and developmental issues interact in contributing to safer sex behaviors. (Contains 85 references and 3 tables.) (JDM)

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Toward an understanding of (Em)Power(Ment) for HIV/AIDS Prevention with Adolescent Women[1]

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Introduction

Preventing the spread of Acquired Immune Deficiency Syndrome (AIDS) among women is a national priority. By mid-1997, nearly 90,000 women in the U.S. had been diagnosed with AIDS (Seattle King County Department of Public Health, 1997), accounting for 15% of all AIDS cases, compared to only 3% of AIDS cases in 1981 (CDC, 1995). In the U.S., AIDS is the sixth leading cause of death among women 18-44 and the rate of infection among women is four times that of men (Kelly, et. al, 1993; Segal, 1993). The World Health Organization estimates that by the year 2000 over 13 million women will be infected with the virus (HIV) that causes AIDS (UN Chronicle, 1994). Within the U.S. and globally, women of color are disproportionately more likely to become infected (CDC, 1995; Land, 1994; UN Chronicle, 1994).

Increasing numbers of women contract HIV through heterosexual transmission (Segal, 1993). The rate of male-to-female transmission of HIV is 12 times more likely than female-to-male transmission (Padian, Siboski, & Jewell, 1990). Women's greater susceptibility to HIV infection are due to both biological and social factors (UN Chronicle, 1994). Differences in male and female anatomy are thought to result in greater susceptibility of women not only to HIV infection, but to infection with other STDs as well, greater difficulty in diagnosing STDs because women are more likely than men to be asymptomatic, and, hence, a higher likelihood of complications from STDs (Holmes, 1990). Moreover, semen has been found to have especially high concentrations of HIV (Segal, 1993). Women diagnosed with AIDS also die sooner after diagnosis than men (Friedland et al., 1991), a result of both biological and social factors.

Social factors, especially women's economic dependence on men, limited access to and control of resources -- especially adequate health care -- play a major role in women's health (Peterson & Marin, 1988; Ulin, 1992). These economic inequalities disproportionately affect women of color, (Jemmott, et al, 1992; Kelley, et al, 1993; Land, 1994; Levine, et al, 1993, UN Chronicle, 1994). Women, especially poor women living in urban environments, are especially vulnerable to HIV infection as the daily challenges of poverty, homelessness, and frequent disruption of their socioeconomic support systems, supersede concerns about sexual safety

(Belgrave, et al, 1993; Mays & Cochran, 1988; Wingood & DiClemente, 1998). Moreover, many women do not exercise the final say over whether to remain abstinent, maintain a mutually monogamous relationship with an uninfected partner, or consistently use condoms, currently the only available means to prevent HIV infection (Mays & Cochran, 1988; Wingood & DiClemente, 1998).

These issues are further complicated when looking at issues related to adolescent AIDS prevention. Although adolescents make up fewer than 1% of all reported cases of AIDS, the higher rate of infection among young adults (20% of all cases) suggest that a substantial number of young adults with AIDS were infected during adolescence (Jemmott & Jemmott, 1994; O'Leary & Jemmott, 1995). Urban and poor youth of color are at particular risk for HIV infection due to overall higher STD infection rates, high teenage pregnancy rates, the presence of injecting drug users in their communities, and the lack of access to health care (Jemmott, et al, 1992; St Lawrence, 1998). Adolescent females may be particularly disadvantaged due to anatomic conditions and physiological conditions that increase their susceptibility for STD infection (Brooks Gunn, et al, 1988) and developmental factors that may make them less likely than adults to feel comfortable with negotiating condom use (O'Leary & Jemmott, 1995). Therefore, the conditions related to HIV/AIDS transmission among women will be greater when considering the experience of adolescents (Jemmott, et al, 1992; O'Leary & Jemmott, 1995; St Lawrence, 1998).

Current efforts toward AIDS prevention education have focused primarily on individual level factors as a means of encouraging behavior change. For example, Fishbein and Azjen's theory of reasoned action (Fishbein & Ajzen, 1975), Bandura's social cognitive theory (Bandura, 1982), and Rosenstock's Health Belief Model (Rosenstock, Strecher, & Becker, 1994) frequently have been used as the basis for identifying factors related to sexual behaviors that place persons at risk of contracting HIV and for developing and testing interventions. These theories are based on the common assumption that individuals have control over the behaviors they perform and that these behaviors are the result of a rational cost/benefit analysis.

Although these theories clearly aid our understanding of intra-individual factors related to AIDS prevention, they fail to take into account the fact that sexual behavior is an inherently dyadic interaction. Because women have less control than men over their sexual behaviors, the power dynamics between men and women represent an important but neglected aspect of AIDS prevention for women (Mays & Cochran, 1988; O'Leary & Jemmott, 1995; Wingood & DiClemente, 1998). As Amaro (1995) points out: "For women...sexual behavior occurs in the context of unequal power and in a context that socializes women to be passive sexually and in other ways" (p. 440).

Successful efforts to change these behaviors also depend on our awareness of deeply entrenched structural factors. Our understanding of the interactions between race, gender, and class can explain the individual's behavior in relation to her larger social context and the role of external factors. Race, gender, and class are not only markers of an individual's identity, but divisions that signify differences, as well as inequalities of all kinds -- economic, social, and political (West & Fenstermaker 1995). The interplay of race, gender, and class is thus complex, because it involves structural, interpersonal and individual factors. A framework that articulates the avenues and barriers that a diverse people face in the course of their everyday lives must also strike a balance between the structural factors that define their world and the efforts, both potential and actual, that they make on their own behalf (Anderson 1996). More specifically, the individual's health practices and our efforts to prevent HIV infection must be examined within the larger social context (Cochran & Mays, 1993; Land, 1994; Mays & Cochran, 1988; Wingood & DiClemente, 1998). This approach may lead to a more comprehensive understanding of health practices and effective interventions that deter the spread of AIDS.

This article represents an attempt to elucidate how an understanding of power -- and empowerment -- are critical elements of AIDS prevention for women. We present data relevant to examining gender differences among adolescents in perceptions of power, predictors of perceptions of power, and examine the relationship of perceptions of power to safer sex behaviors.

We hope that this discussion will assist our understanding of how these dynamics play a role in preventing the spread of HIV and AIDS among adolescent women.

A gendered perspective on AIDS prevention with women

Our understanding about the implications of gender for health practices may be advanced by a framework that features both the structural and the individual and that shifts our perspective to their interaction. Inequality is built on ideas about gender, and inequality, in turn, reifies the subordination of women through a massive network of structures, processes, and relationships. Women live in this environment, negotiating a better life, struggling against constraints, and sometimes, accepting it as is. Women are disadvantaged because of gender -- in interaction with race and class -- and yet they can actualize their own, personal agendas.

The power to negotiate, struggle, and accept, despite the larger social context, is an integral component of health practices. Inequalities within a society silence women and our expression of sexuality, which in turn, may endanger health and well-being. Research suggests that adolescent women are already aware of many of these dynamics (O'Leary & Jemmott, 1995; Olsen, 1996). A qualitative study of a racially heterogeneous sample of 30 adolescent girls found that sexual desire was not an easy topic to talk about, partly because "they (we)re denied full access to the power of their own desire and to structural supports for that access" (Tolman 1994). Urban girls reported that they had to first ensure their physical safety before they entertained thoughts about having sex and what they wanted. Suburban girls were concerned with their virtue and being 'good' and 'normal'. In both cases, being young women in our society played an integral role in the processes that led to their behaviors. These girls did not have unobstructed opportunities to think about sex, depriving them of the chance to explore their sexual desires, to develop their own power to trust their instincts, and to cultivate a stronger sense of self to make the healthiest, safest decisions throughout their lives.

Other studies have also drawn a connection between the larger, social context and the individual. Withers et al. (1993) focused on the interaction of race, gender, and class to understand AIDS risk among 694 African American women, Latinas, and European American

women from county jails, public and community health services, and other sources. Among all women with a steady partner and who did not discuss using a condom, 81% reported that they never used a condom, suggesting that disempowerment led to unhealthy practices among women. However, attitudes about gender subordination, including telling men what to do about contraception and God's intent about equality between women and men, explained only 12.6% of the total variance (Withers et al. 1993). Black women and/or women who had less than a high school education were more likely to use a condom. It was argued that condoms were cheaper than other forms of birth control, and consequently, Black women and/or women with less education had access and experience before the onset of the AIDS epidemic (Withers et al. 1993). Attention to race and class, as well as gender, is necessary to understanding the complex processes that operate between individual and environment. Gender does not function without the other two (Anderson 1996; West & Fenstermaker 1995) and acknowledging that interrelationship may be critical to our understanding about health practices and risks among women.

This gendered understanding of HIV/AIDS prevention calls for a contextualized perspective in considering how women protect themselves from infection. Empowerment theory is one effort to study how perceptions of power effect behaviors (Gutiérrez, 1990; Kelly, et al, 1993; Land, 1994; Levine, et al, 1993). This theory has emerged to explain how individuals can increase their power (Fay, 1987) through social interaction (Friere, 1973; Gutiérrez, 1990; Kieffer, 1984; Pinderhughes, 1989; Rappaport, 1981; Solomon, 1976; Stensrud & Stensrud, 1982). Empowerment is posited as a means of addressing the problems of relatively powerless populations and by mediating the role powerlessness plays in creating and perpetuating social problems (Gutiérrez, 1990; Pinderhughes, 1989; Solomon, 1976).

Empowerment theory incorporates a feminist view of power as a positive force in the lives of women and other disenfranchised groups (Bricker-Jenkins & Hooyman, 1986; Katz, 1984). It assumes that power is not a limited, but can be generated in the process of social interaction. Empowerment theory focuses on increasing three different kinds of power (Dodd & Gutiérrez, 1991):

Personal Power involves experiencing oneself as an effective and capable person. One means of increasing personal power is to identify and understand the power one already has. In relation to HIV prevention for adolescent women it would involve analyzing and understanding ways in which they can take charge of their own health status through engaging in safer sex behaviors. In some ways, this conceptualization of personal power appears very similar to Bandura's (1982) concept of self-efficacy. It differs from efficacy by focusing less on expectations of outcomes regarding ones behavior and more on understanding the actual choices, skills, and options one has in a situation. This conceptual differentiation is supported by analyses we have undertaken in which measures of self-efficacy loaded on a different dimension than measures of personal power, suggesting that they are distinct, albeit related, constructs (Gutiérrez, Morrison, & Gillmore, 1995).

Interpersonal Power is the ability to influence others through the use of social power. Social power derives from such things as one's social position, role, interpersonal skills, credibility, or attractiveness (Feld, 1987; French & Raven, 1968). Some of these bases of power are ascriptive -- based on race, gender, or class -- but others can be achieved as one develops social skills or attains new social positions. Therefore, identifying skill deficits and learning new skills is a key element of the empowerment process. When thinking about women's health, and HIV prevention, this might involve developing the skills to negotiate relationships with health care providers and significant others.

Political power is the ability to influence the allocation of resources in an organization or community through formal or informal means (Parenti, 1978). Political power is most commonly gained through collective action and collaboration with others. Through the lens of HIV and women's health this would involve work to impact on the conditions which shape adolescent women's health: stress, access to food, shelter; or stopping violence against women. Efforts would be made to work with others to affect health and social policy, research, and access to existing services (Cochran & Mays, 1993; Howes & Alicia, 1994; Kelly, et al, 1993; Lucky, 1996;)

Empowerment theory is based on an interdisciplinary understanding of power. Its roots are in sociology, psychology and political science. For example, it draws upon Emerson's power-dependence theory (Emerson, 1962; 1972a,b). This theory describes power as an attribute of social relations and the dependence of systems or individuals to obtain valued resources. According to power-dependence theory, two variables govern dependence: the value (or desirability) of the resource received and the availability of this resource from alternative sources. Power is thus an inverse function of dependence: the more dependent one person is on the other, the less power that person has in that relationship. This notion is very similar to the principle of least interest (Kuhn, 1964) which states, in effect, that the person receiving the least benefit in a bargaining situation has the greater bargaining power. This theory can explain one way in which the larger structural aspects of gender inequality can impact on interpersonal relationships

Empowering women requires this contextualized understanding of power in different dimensions. It requires combining a sense of personal control with the ability to influence the behavior of others, focusing on enhancing the existing strengths in individuals or communities, and establishing equity in the distribution of resources (Bricker-Jenkins & Hooyman, 1986; Katz, 1984; Kieffer, 1984; Rappaport, 1986). A feminist perspective on empowerment focuses specifically on how women have been affected by forces such as racism, ethnocentrism, and sexism and on ways in which social structures can be challenged. Because women lack political power, we must look at ways to work toward the interpersonal and political levels of empowerment. Gaining a sense of personal power must be viewed as only the first step toward the ultimate goal of changing oppressive structures (Bricker-Jenkins & Hooyman, 1986; Gould, 1987a; Gutiérrez, 1990).

The concept of empowerment is not without controversy. Much of the current literature on empowerment has focused primarily on the intrapersonal and psychological dimensions of empowerment, which are often equated with perceived control or self efficacy (Riger, 1993). This individual focus has disregarded work that focuses on the importance of connection and community to the empowerment process, and has not reflected a new paradigm for thinking about

women's experience. If empowerment is to contribute to the lives of women, our focus must be on ways in which it can improve the material conditions of women's lives (Bricker-Jenkins & Hooyman, 1986; Gould, 1987a; Gutiérrez, 1990; Levine, et al, 1993; Riger, 1993).

The literature regarding women, empowerment and AIDS has been primarily theoretical and descriptive (Amaro, 1995; De Bruyn, 1992; Fullilove, Fullilove, Hyness & Gross, 1990; Holland, Ramazanoglu, Schott, Sharpe & Thomson, 1992a; Holland, Ramazanoglu, Schott, Sharpe & Thomson, 1992b; Kline, Kline & Oken, 1992; Maxwell & Boyle, 1995) and only recently has begun to be tested (Gomez & VanOss Marin, 1996; Kline & VanLandingham, 1994; Levine, et al, 1993). In an attempt to begin filling this gap, we present data on the role of empowerment in prevention of the spread of HIV/AIDS in a sample of heterosexually active adolescent women. Because of the nature of our study, our focus was on the personal and interpersonal aspects of power in relationships, rather than political power. These analyses are not meant to be definitive, but rather they are intended to be thought provoking. Three main questions are addressed:

1. *Are there differences between adolescent young women and men in their perceptions of their personal and relationship power?*

Both structural and socialization arguments suggest that relative to perceptions of men, women would perceive themselves as less powerful. Because these factors begin to exert their influence very early in life, we expect that such differences would be evident by adolescence. Therefore, we predict that relative to young men's perceptions of themselves, young women will perceive themselves as less powerful.

2. *What factors are related to perceptions of power?*

Research on power and empowerment suggest that a combination of structural, inter-personal and intra-personal factors are important to consider. From a power-dependence point of view, we expect that those who are themselves younger, those who are much younger than their partners and those who perceive their relationships with their partners as very important to them, will feel less empowered in the relationships. From a structural point of view, we expect that

gender, race, and age will affect adolescent's perceptions of personal power. Experiences with sexual and physical abuse is also likely to affect perceptions of both personal and relationship power (Wyatt & Riederle, 1994).

We also examine the effects of intra-personal variables that we expect will have an effect on perceptions of power. We expect that partners who are more knowledgeable, perceive less personal risk of AIDS, have greater condom negotiation skills and greater self-efficacy about negotiating condom use will feel more empowered in their interpersonal relationships.

3. *Are perceptions of power in relationships related to adolescent women's ability to engage in safer sex behavior?*

We predict that relationship power will be positively related to condom use, even when controlling for variables that would be expected to be related to condom use. The rationale for this prediction is that the person in the relationship who perceives her- or himself to be more powerful and influential in the relationship will be more successful negotiating safer sex, as reflected in condom use.

The research on gender has increasingly focused on the importance of a contextualized understanding of how gender, race, ethnicity, and class interact in affecting attitudes and behavior (Comas-Diaz & Greene, 1994). Therefore, in this study we will consider these questions from the perspective of race and gender in interaction. An overarching theme is the ways in which African American and European American young people relate to power and empowerment in different and similar ways.

Method

Sample

The data for this paper come from a larger study in which interventions to reduce adolescent's risk of AIDS were developed and tested (c.f. Gillmore et al., 1997). For that study, 508 heterosexually active African American and European American adolescents between the ages of 14 - 19 were recruited from urban public health clinics (primarily an STD clinic) and an urban juvenile detention facility. These populations were selected because they are at particularly high

risk for HIV/AIDS infection. The majority of the young people in public health clinics identified for the study were seeking reproductive related health services and therefore were sexually active or intending to engage in sexual activity. Although the adolescents in detention were not seeking reproductive health services, this population has been found to have higher rates of behaviors associated with STD infection such as multiple sexual partners, early initiation into sexual activity, drug use and abuse, and low rates of condom use (Belgrave, et al, 1993; Jemmott & Jemmott, 1994). The intention of this study was not for a representative sample of adolescents, but for one at high risk for HIV infection (Gillmore, Morrison, Richey, Balassone, Gutiérrez, & Farris, 1997).

To be eligible for study participation, the adolescent had to be between ages 14 - 19, heterosexually active in the past three months, not planning to move out of the area for the next six months (this criterion was to enable longitudinal follow-up), and for those in juvenile detention, likely to be released within the next month (to allow for the opportunity to engage in sexual behavior during the period of follow-up). An attempt was made to balance both gender and race by recruiting approximately equal numbers in each gender/race group. The analyses reported in this paper are based on responses to questionnaires that were administered to participants upon enrollment in the study prior to intervention. Because the outcome variable is condom use with steady partners, only those participants who reported sexually activity with steady partners (n = 333) were included. This sample is 51% male, 49% female, 50% African American and 50% European American. Participants were on average 16 years old and had completed an average of 9.6 years of school. Most of the mothers (71%) of the respondents had completed high school, and some (46%) had schooling beyond high school. Within the total sample, the majority (84%) report having had sex in the prior three months with a steady partner, and nearly half (45%) report having had sex with a casual partner during this time.

Procedures

Potential study participants included all those meeting the eligibility criteria. A member of the research team approached potential participants individually to briefly describe the study.

Interested youths were taken to a private area and screened for eligibility. Non-eligible youths were thanked for their time. The interviewer further described the study to eligible interested youths and insured that the youth understood that he or she was free to refuse to participate and would suffer no repercussions for not participating. To protect participant's privacy, staff of the clinics and juvenile detention facility were not informed as to which adolescents agreed to be in the study. Because Washington state law allows minors to obtain reproductive health care without parental permission, informed consent from parents was *not* obtained because of the possibility it would violate the adolescent's right to privacy.

After obtaining informed consent from the participants, and locator information for the follow-up, a pre-test questionnaire was administered to obtain information on socio-demographic variables, sexual history, and variables expected to be changed through intervention (e.g. attitudes, beliefs, intentions, perceptions of power, knowledge of STDs). To ensure that reading difficulties were not a problem, study participants were given the option of filling out the questionnaire themselves or having the interviewer read it to them while they followed along and marked their responses on their own copies. Most study participants filled out their own questionnaires. The interviewer remained in the room to answer any questions the study participant might have, but tried to remain relatively unobtrusive. Study participants also were given an opportunity to ask questions following delivery of the questionnaire. All participants were paid $10 for the pretest session. In addition, all participants received a "gift bag" containing a thank you note, samples of three or four condoms, a key chain containing a condom holder case, and a candy bar. Juvenile detention regulations stipulated that the payments and other gifts be held for the study participant and delivered upon release.

Several steps were taken to help ensure that the questionnaire items were age, gender and ethnically appropriate, and that the questionnaire was easy to understand and follow even by adolescents with lower literacy levels. First, many of the items had been carefully developed, pretested extensively, and used successfully in a prior study with adolescents sampled from the same population. This stage of pretesting and measure development involved focus groups with

young people in community settings in an effort to be developmentally, gender and ethnically appropriate (Morrison, Baker & Gillmore, in press). Second, a panel of community service providers who work extensively with adolescents reviewed the questionnaire for appropriateness for the population and their suggestions were incorporated into the questionnaire. Third, the research team carefully evaluated the questionnaire for simplicity and places where simpler words could substitute for a more complex word without changing the meaning of items. Fourth, the final draft of the questionnaire was carefully pretested with members of the target population to ensure it was comprehensible and easy to follow. A few final changes were made as a result of this pretesting. Finally, as noted above, the participants were provided with the option of filling out the questionnaire themselves or having it interviewer administered. As part of the data quality control procedures, all questionnaire responses were carefully examined for any evidence that participants were not taking the questionnaire seriously or were experiencing difficulties responding to the questions. There was very little evidence of problems (e.g., nonsensical responses, missing data, response set bias, etc.).

Measures

Empowerment: Work on measuring empowerment is in its infancy and most measures have focused on its personal or political dimensions with none involving the dimensions of interpersonal empowerment (Zimmerman, et al 1992; Clark, et al, 1995; Koren, et al, 1992; Schulz, et al, 1994). Yet, it is the interpersonal dimensions of power that are most relevant for understanding women's AIDS risk. Wherever possible, we adapted items from the literature on empowerment and social power, but we also developed some measures specifically for the purposes of this study owing to the paucity of measurement work in this area. Descriptions of these measures are in Table One

Eight items, adapted from the literature on empowerment, were included that tapped perceptions of *personal power*. Examples include: "I have a realistic chance of accomplishing my personal goals and "I feel strong as a person". Each item was scored on a 7-point scale anchored

at the endpoints by "strongly disagree" and "strongly agree," with higher scores indicating greater feelings of personal empowerment.

Four other *relationship power* items were developed for the purposes of this study. Examples include: "There is little I can do to change my relationship with this partner" and "I am not afraid to differ with this partner." Each of these items was scored on a 7-point scale anchored at the endpoints with "Strongly disagree" and "Strongly agree." Higher scores indicate greater empowerment. Exploratory and confirmatory factor analyses on these three scales were performed and revealed the presence of three dimensions that are related to but distinct from self-efficacy (Gutiérrez, Morrison & Gillmore, 1995).

Four items were also developed to tap *interpersonal power.* These items, adapted from the work of Blumstein and Schwartz (1983) began with the stem: "Who has the most say..." followed by situations such as when to see each other, whether to have sex, etc. These items were scored on a 5-point scale on which a "1" was labeled "I have all the influence", "3" was labeled "We have equal influence," and "5" was labeled "He has all the influence." Items were scored such that higher scores meant greater influence in the relationship. To reduce social desirability, the stem of the question said "Although you and [partner] may have equal say in most decisions, we would like to know who has the most say about each of the following...".

Items loading on each of the three dimensions were averaged to form three scales. We labeled these three scales: Personal Power, Relationship Power, and Interpersonal Power. Table 1 lists the items comprising each scale, and the associated scale reliabilities (Cronbach's alpha). These alphas are in the moderate range and it is likely that these levels are strongly influenced by the small number of items used in constructing the scales.

Structural variables: Four socio-demographic variables were included and all are based on self-reports. Gender was coded "1" for females, "0" for males. Race was scored "1" for African American, "0" for European American. Age was the number in years provided in response to the question "How old are you?".

Intra-personal variables: Six measures of intra-personal characteristics relevant to AIDS risk were included: Age at first intercourse, AIDS/STD knowledge, perceived risk of AIDS, condom negotiation self-efficacy, skills, and life stress.

Age at first intercourse was the number of years in response to an item that asked "How old were you the very first time you had sex with a male (his penis in your mouth, vagina, or rectum) by your own choice?" (appropriately re-worded for male participants). Because we were unable to ask participants directly about experiences of sexual abuse, we considered very young answers to this question to be a proxy for child sexual abuse.

AIDS/STD knowledge was measured by a 15 item scale that had been used in prior research (Morrison, Baker, & Gillmore, 1994). Examples of items include: "A person can look healthy and still give a sexual partner the AIDS virus," "Someone with a sexually transmitted disease might not have any signs or symptoms of it". Study participants checked "true" or "false" for each item. The knowledge score consisted of the sum of correct answers.

Perceived personal risk of AIDS infection was measured by an item that asked: "What do you believe is your own PERSONAL RISK of getting infected with the AIDS virus in the next 6 months?" Responses were scored on a 4-point scale ranging from 1 = high risk to 4 = no risk. Items were reverse scored so that higher scores indicated greater risk.

Self-efficacy regarding condom use was measured by four items that asked: "... How likely is it that you could think up a good way of talking about using condoms?", "How likely is it that you could talk to your steady partner about using condoms?", How likely is it that you could get [him/her] to agree to use one?" , "....if [he/she] said no, how likely is it that you could bring it up again at another time?" These items were scored on a 7-point scale labeled at the endpoints with "Very unlikely" and Very likely;" higher scores indicated greater sense of self-efficacy. The alpha co-efficient for this scale is .89.

Life stress was measured by 14 items that asked whether or not each of the events had occurred in the past year. This list was developed to reflect the experiences of adolescents in this sample. Examples of items included "moved to a new home," "got suspended or expelled from

school," "parents got divorced or separated" "scary alcohol or drug experience," spent a night on the streets or in a shelter." Each checked item was given a score of one, and these scores were then summed to form the life stress measure.

Skills in discussing condom use with partners were measured through open ended responses to trigger vignettes that presented risky situations. These vignettes were developed based on "risky situations" described by community youth in focus group sessions. Participants were asked to indicate what they would do in each situation and how effective they felt they would be. Four independent coders were trained to reliability, with periodic assessments of inter-rater reliability and re-trained when indicated. All coder disagreements were resolved by one of the investigators whose expertise is in the area of skill training. The average agreement over all types of codes was 81%. A scale was developed using a count of all distinct responses coded to each vignette. This represents a varied repertoire of skills for discussing and negotiating condom use.

Inter-personal variables: Three measures of inter-personal variables were included. Age difference between the study participant and his or her steady partner was measured as the difference in years (score = male - female age). Importance of the relationship was measured by a single item that asked with regard to the steady partner: "How important is your present relationship to you?" scored on a 7-point scaled labeled at the endpoints "Not very important" and "Very important;" with higher scores indicating greater importance. Condom use was measured by a single item used in prior research that asked: "In the past 3 months, how often have you used condoms for vaginal sex (penis in vagina) with your steady partner?" (Morrison, Baker & Gillmore, in press). Responses were scored on a 5-point scale ranging from never to every time sex occurred, with higher scores indicating greater condom use.

In order to evaluate the comparability of participants recruited at the clinic or detention settings, T-Tests were run on all measures to compare the two sample recruitment sites. These analyses found some significant differences between the samples in respect to age, age at first intercourse, knowledge, life stresses, and skills. As these items were to be assessed and accounted for in all subsequent analyses, the two samples were combined in order to gain greater

statistical power. Because of the nature of the differences observed, there would be no independent effect to be contributed due to the specific site.

Additionally, a correlation analysis was conducted to investigate the bivariate relationships among the independent and dependent variables. This analyses identifies the relationships between site and other variables identified by the T-Tests. Additional highly significant correlations (above .40) were found between gender and the age of one's steady partner and gender and the age difference between oneself and one's partner. These results support previous literature that has found that adolescent women are more likely to have older male partners. The pattern of results in this correlation matrix identified no strong significant relationships between the variables that should affect the results.

Results

The first analyses examined gender differences in the three dimensions of perceived power and addressed the question: Do adolescent women and men view their personal power, interpersonal power, and relationship power differently? Table Two presents descriptive statistics for each of these measures broken down by race and gender. These data support the prediction that adolescent women view themselves as having less personal and interpersonal power than do adolescent men. This was true for both European American and African American participants. However, this observed difference is statistically significant only for interpersonal power. This trend was not found for relationship power. African American women had higher scores on relationship power than the other three groups. However, this difference was not statistically significant.

The second analyses used multiple linear regression to examine factors that we expected to be associated with perceptions of power. Our prediction was that respondents with greater perceptions of power would be male, older, closer in age to their partners, older when they first experienced intercourse, less invested in their relationship, more knowledgeable about AIDS/HIV infection, more skillful in discussing condom use, and reporting fewer life stresses. Separate multiple regression equations were estimated for each group for the three dimensions of power.

Results from these regressions analyses suggested different patterns of predictors for each dimension of power and each group (Tables Three, Four and Five). The model was most predictive of the variance in personal power for African American men. Knowledge of HIV/AIDS was significant in the predicted direction. Importance of the relationship and average skill level were significant in the opposite direction. The model predicted 41% of the variance for this group. Self efficacy for condom use with steady partner was significant for European American women and men in the predicted direction. Relationship importance was significant in the opposite direction for European American men and age at first intercourse was significant in the opposite direction for European American women. Knowledge of HIV/AIDS transmission was the only significant predictor for African American women.

This model was most useful in predicting Interpersonal power among the European American participants. For European American men, relationship importance and knowledge of HIV/AIDS were significant in the expected direction, skill level was significant in the opposite direction. For European American women, relationship importance and the age difference with steady partner were significant in the expected direction. This model was not predictive of the variance within the African American participants.

The third regression analyses predicting Relationship Power measured the degree of power the respondent experienced in their relationship with this specific partner. This model was most useful in accounting for the variance among the female participants. Self efficacy for condom use with steady partners was significant in the expected direction for African American women. Relationship importance was significant in the opposite direction. Among the European American women, only skill level was significant in the predicted direction.

A third set of analyses were conducted to identify those variables that predicted condom use with steady partners. The dependent variable was responses to an item that asked them to indicate the number of times they had used a condom with their steady partner during vaginal sex during the previous three months. The independent variables were the variables used in the previous analyses in addition to personal, interpersonal and relationship power. (Table Six). Each

regression was run separately for each group. The proportion of the variance accounted for in this model ranged from 14% to 30% with different patterns for each group. This model was most useful in predicting the variance among the female participants. Age at first intercourse, perceived risk of AIDS, self efficacy for condom use and relationship power predicted 30% of the variance for African American women. Younger age and relationship importance predicted 28% of the variance for European American women.

Discussion

In this article, we hoped to stimulate interest in the power dynamics of relationships and how these might influence adolescent women's HIV risk. Toward this end, we explored how high risk adolescents view their personal power, the degree to which they see themselves as powerful in their ability to influence their steady partner and their relationship, and if these perceptions of power improve their ability to engage in safer sex behaviors. These preliminary analyses lend some support to previous theory and qualitative studies that suggested that adolescent women's power and empowerment should be a consideration of HIV prevention among high risk adolescents. However, they also suggest that our understanding of power dynamics in relationship are complex and must be contextualized in respect to gender and race.

Results from our first analysis support assertions that adolescent women experience themselves as less powerful than men in respect to interpersonal power. Although adolescent women in this study rated themselves lower than the adolescent men on personal and interpersonal power, the difference was statistically significant only for interpersonal power. No statistically significant differences existed for relationship power.

This difference in perceived interpersonal power supports the notion that young women may not experience the level of power in their relationship to negotiate safer sex with their partner. In one study of adolescent condom use, the young women reported that they tend not to ask their male partners to use condoms because they thought that their partners would refuse. Ironically, the young men said that they would be willing to use condoms if their female partners asked them to (Kegeles, Adler, & Irwin, 1988). These findings, along with those of the present study, suggest

that approaches that focus on empowering young women may provide them with sufficient confidence to ask their partners to use condoms. Skills training approaches have sometimes (e.g., Jemmott III, Jemmott, & Fong, 1992), but not always (e.g., Gillmore, et al., 1997) reduced adolescent young women's risk of AIDS.

Our analyses also suggest that structural, inter-personal, and intra-personal factors contribute to differing perceptions of one's personal power and power in relationships. Very different patterns of predictors were identified for each gender and racial group. These results support a critical element of empowerment theory that considers different dimensions of power (personal, interpersonal, and political) separately. Each dimension of power may operate independently and relate to different aspects of behavior. They also reinforce the importance of understanding power in context.

Among the African American male participants, knowledge, greater relationship significance and fewer skills were associated with *Personal Power* while self efficacy predicted personal power for the European American participants. The unexpected positive relationship between relationship significance and personal power supports work on the Africentric model for HIV/AIDs prevention that emphasizes the importance of connection and community for African Americans over self efficacy and individual needs (Cochran & Mays, 1993; Fullilove, et al, 1990; Jackson & Sears, 1992; Lucky, 1996). These African American participants may experience more power in connection with others than a sense of power that is decontextualized from others.

The results for predicting *Interpersonal Power* supports a critical aspect of power dependence theory among the European American participants. For these participants, greater feelings of interpersonal power was associated with less relationship significance and, among females, with a closer age difference with the steady partner. This suggests that for these participants feeling less dependent on one's partner is related to experiencing more influence in the relationship. This pattern was not found for African American participants.

The regression model was predictive of *Relationship power* among the female but not the male participants. Greater skills were associated with relationship power for European American

females and greater relationship importance and self-efficacy were significant for African American females. These results suggest that skills training might be more effective in the empowerment of European American young women in contrast with increasing self efficacy and focusing on connection for African American young women. The findings regarding connection and empowerment for the African American participants supports the Africentric model discussed previously.

The results on predicting condom use support the importance of understanding and recognizing gender and racial differences. This model was most useful in predicting condom use among the African American female participants. For these participants, older age at first intercourse, perceived personal risk for AIDS, self efficacy for condom use and greater relationship power were associated with condom use. These findings support the predictions based on empowerment theory. For European American women, older age, and less relationship importance were associated with condom use. These findings are also in support of empowerment theory. This model was not useful in predicting condom use among the male participants. This suggests that notions of power and empowerment may be less salient for them in making decisions regarding safer sex behavior.

What does this study tell us about the utility of empowerment theory in understanding issues of HIV/AIDS prevention in high risk adolescent women? These analyses found that although these young women in general perceived themselves as less powerful than young men in general, these perceptions of power were less important than other variables in predicting condom use. These findings may have been affected by the inadequate measures that exist for operationalizing and measuring power and empowerment. The measures that were created specifically for this study had face validity and moderate levels of internal reliability. Although they were grounded in the theoretical literature on empowerment, they may not have been adequate for measuring power in relationships. Future research is needed that will consider more valid and reliable means for measuring power before the utility of empowerment theory can be fully assessed.

However, these findings do support the theoretical perspective that our understanding of power in relationship be viewed from a contextualized gender lens. The pattern of results support previous research that have found racial and gender differences in viewing power, relationships and condom use. The models tested here were most effective in predicting condom use among high risk adolescent women, particularly African Americans. This suggests that a different model would be useful for understanding condom use among high risk adolescent males. Overall this study told us less about the experience of adolescent males in respect to power and condom use. This suggests the need for future research that will look at adolescent males and females separately in respect to what predicts condom use and safer sex behavior.

Although this study of a small sample of high risk adolescents can not be generalized to all adolescents, their experience can be useful for understanding ways in which HIV/AIDS prevention can efforts can be designed and delivered. This study supported the notion that African American young women would benefit from educational methods that emphasize their personal risk for HIV/AIDS and that increase feelings of self efficacy in discussing condom use with partners (Mays & Cochran, 1988; Wingood & DiClemente, 1998). HIV/AIDS prevention oriented toward European American adolescent women could be focused on ways to develop power within their relationships. These issues would be less significant in HIV/AIDS prevention for adolescent males.

Preventing the spread of HIV and AIDS among adolescents should be a national priority. However, prevention will not take place unless we have a clear understanding of the ways in which gender, culture and developmental issues interact in contributing to safer sex behaviors. Increasing our understanding will require a variety of methods that will give voice to the experiences of high risk adolescents. Only through developing this contextualized knowledge will we begin to understand issues of power and empowerment in preventing HIV and AIDS with adolescent women.

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TABLE ONE: Measures of Empowerment

Personal Power
Summary scale based on average scores on the following items. Higher scores indicated greater perceived personal power:
• I have a realistic chance of accomplishing my personal goals. • I can live according to my personal values. • I feel strong as a person
Alpha coefficient is .68
Relationship Power
Higher scores indicate perceptions of greater influence over the partner.
• There is little I can do to change my relationship with this partner • When I am with this partner, I have found it hard to stay committed to goals I set for myself • This partner can easily win an argument with me
The alpha coefficient for this scale was .58
Interpersonal Power
Who has the most say over the following:
• when to see each other • what to do when we go out • whether to have sex • whether to use a condom
The alpha coefficient for this scale is .68

Table 2

Variable Descriptives, Overall and by Gender and Race

	Overall		Female		Male	
			Af Am	Eu Am	Af Am	Eu Am
	M	SD	M	M	M	M
Age*	16.36	1.45	16.26	16.14	16.15	16.96
Age Difference*	2.05	0.79	1.74	1.63	2.47	2.53
Age First Intercourse*	13.41	2.12	14.10	13.70	12.04	13.53
Average Skill Level*	7.56	2.10	7.33	8.30	6.96	7.53
Relationship Importance	6.17	1.53	6.09	6.40	6.09	6.07
Knowledge about HIV/AIDS*	13.50	1.60	13.11	13.72	13.24	13.97
Personal Risk of AIDS*	2.96	0.67	3.12	2.91	2.88	2.88
Life Stresses	5.52	0.67	5.12	5.84	5.34	5.81
Overall Self-Efficacy for Condom Use with Steady Partner	5.94	1.53	5.84	5.83	5.94	6.20
Overall Interpersonal Power*	3.13	0.71	3.05	2.95	3.32	3.26
Overall Personal Power	5.92	1.06	5.93	5.71	6.02	6.05
Overall Relationship Power	4.83	1.36	4.99	4.69	4.83	4.80
Number of Times Condom Used with Steady Partner, Vaginal Sex	2.76	1.59	2.61	2.61	2.88	3.03
N	333		93	92	73	75

Note. The asterisk (*) denotes significant differences at the $p < .05$ level in mean values across race and gender groups.

Table 6

Regression Models Predicting Number of Times Condom Used with Steady Partner, Vaginal Sex, in Last 3 Months, by Race and Gender

	Female				Male			
	Af Am		Eu Am		Af Am		Eu Am	
Age	0.02		-0.31	**	-0.10		-0.27	
Age Difference	-0.39		-0.11		-0.02		0.13	
Age First Intercourse	0.37	**	0.00		-0.03		-0.10	
Average Skill Level	-0.07		0.01		-0.05		0.06	
Relationship Importance	-0.01		-0.45	**	-0.11		-0.06	
Knowledge about HIV/AIDS	-0.12		-0.01		-0.26		-0.32	
Personal Risk of AIDS	0.73	**	-0.39		-0.14		0.27	
Life Stresses	0.01		0.02		-0.08		-0.05	
Overall Self-Efficacy for Condom Use with Steady Partner	0.25	**	0.18		0.10		0.16	
Overall Interpersonal Power	0.04		-0.21		-0.15		-0.46	
Overall Personal Power	-0.08		0.27		0.45		0.05	
Overall Relationship Power	0.23	*	0.06		0.01		0.22	
Constant	-4.74		9.51	**	7.01		11.58	**
Adjusted R^2	0.30		0.28		0.14		0.28	

Note. *p < .10. **p < .05.